

**STATE OF NEW JERSEY
EMERGENCY OPERATIONS and RESPONSE PLAN
EMERGENCY SUPPORT FUNCTION #8
Public Health and Medical Services Annex**

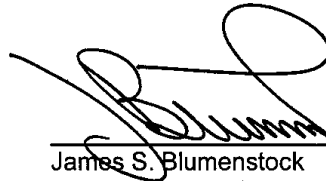
I. Statement of Approval

The New Jersey Department of Health and Senior Services, Public Health and Medical Services Annex, (Emergency Medical Services portion of the annex) meets the approval of the Department and is hereby approved.

This portion of ESF #8 annex supersedes any previously written Emergency Support Functions for Emergency Medical Services.

Approval Date: _____

5/9/05



James S. Blumenstock
Deputy Commissioner
Public Health Protection and
Emergency Preparedness

STATE OF NEW JERSEY
EMERGENCY OPERATIONS and RESPONSE PLAN
EMERGENCY SUPPORT FUNCTION #8
Public Health and Medical Services Annex

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EMERGENCY OPERATIONS and RESPONSE PLAN
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STATE OF NEW JERSEY
EMERGENCY OPERATIONS and RESPONSE PLAN
EMERGENCY SUPPORT FUNCTION #8
Public Health and Medical Services Annex

PRIMARY AGENCY:

New Jersey Department of Health and Senior Services (DHSS)

SUPPORT AGENCIES:

New Jersey Association of Paramedic Programs
New Jersey State First Aid Council
Medical Transportation Association of New Jersey
National Disaster Medical System
New Jersey Department of Environmental Protection
New Jersey Department of Military & Veterans' Affairs
New Jersey Department of Human Services
New Jersey Hospital Association
New Jersey Office of Emergency Management
New Jersey Office of the Medical Examiner
New Jersey Critical Incident Stress Management System

I. INTRODUCTION

A. Purpose

The Department of Health and Senior Services has divided Emergency Support Function #8 (Public Health and Medical Services Annex) into five distinct functional areas of Public Health and Health Care to include:

1. Public Health;
2. Health Care - Hospitals, Blood Banks, Long Term Care, Federally Qualified Hospitals, etc;
3. Emergency Medical Services;
4. Laboratories; and
5. Bio-Terrorism.

This particular portion of the Public Health and Medical Services Annexes deals specifically with the Emergency Medical Services (EMS) aspects of ESF#8.

The EMS portion will provide for the coordination and direction of state, county, municipal, private, non-profit and volunteer emergency medical services resources; and support public health and emergency medical services needs before, during or after a major/catastrophic disaster or acts of terrorism.

B. Scope

The overall scope of ESF#8 involves supplemental assistance to local governments in identifying and meeting the public health and medical services needs to victims of a major emergency or disaster. This support is categorized in the following functional areas, including but not limited to:

1. Assessment of emergency medical services needs;
2. Assessment of pre-hospital health care personnel;
3. Assessment of emergency medical services equipment and supplies;
4. Assessment of patient evacuation by emergency medical services;
5. Assessment of in-hospital care resources;
6. Assessment of medications/medical device safety;
7. Assessment of emergency medical services worker health safety;
8. Assessment of chemical, biological, radiological, nuclear, and explosive hazards to emergency medical services personnel;
9. Assessment of emergency medical services mental health accessibility (i.e., Critical Incident Stress Debriefing/Critical Incident Stress Management – CISD/CISM);
10. Assessment of public health information pertaining to emergency medical services;
11. Assessment of victim identification;
12. Assessment and evaluation of the health threat to emergency medical services personnel and the general public;
13. Provides overall coordination for statewide emergency medical services response;
14. Implements the necessary controls to prioritize the allocation of resources to meet requests which temporarily exceed local and county assets;
15. Coordinates the New Jersey Emergency Medical Service Task Force resources throughout the State;
16. Provides coordination for obtaining and distributing resources from the Federal level in support of local agencies and;

17. Manages Disaster Medical Assistance Teams (DMAT).

II. POLICIES

- A.** Emergency Support Function #8- Public Health and Medical Services Annex is implemented upon the activation of the NJ Emergency Operations Plan or the appropriate county-level request for Emergency Medical Services assistance.
- B.** This annex fully supports and implements the National Response Plan, the State of New Jersey Emergency Operations Plan, Public Law-288, the National Incident Management System as amended, and the State of New Jersey Emergency Management Act. The annex provides for the coordination of Emergency Medical Services support to county and municipal governments, private and volunteer organizations in the execution of their emergency operations plans. All resources will be coordinated and used as a unified response.
- C.** Emergency Support Function #8- Public Health and Medical Services Annex Emergency Medical Services portion will insure that all emergency medical services will be provided without regard to economic status or racial, religious, political, ethnic, or other affiliation.
- D.** All Emergency Medical Services resources are coordinated through the New Jersey State Police Emergency Operations Center (NJSP EOC), in conjunction with the Health Command Center (HCC), when Emergency Support Function #8- Public Health and Medical Services Annex is activated.
- E.** In accordance with the Emergency Medical Services assignment of responsibilities in Emergency Support Function #8- Public Health and Medical Services Annex, and further tasking by the primary agency, each support organization participating under Emergency Support Function #8- Public Health and Medical Services Annex contributes to the overall response but retains full control over its own resources and personnel. This is accomplished through the unified command structure using the state, county, and local emergency management chain of command.
- F.** All municipal, county, private and volunteer organizations participating in response operations report Emergency Medical Services requirements to their next higher reporting authority following the National Incident Management System (NIMS) model. Scene incident commanders report to local EOCs who report to county EOCs who report to the NJSP EOC.
- G.** The Commissioner of the Department of Health and Senior Services is authorized to release information of general medical and public health

information to the public. Requests for recurring reports of specific types of medical and public health information are submitted to the NJSP EOC as soon as information requirements are identified to enable development and implementation of procedures for recurring Situation Reports.

- H. Emergency Support Function #8- Public Health and Medical Services Annex does not release medical information on individual patients to the public to ensure patient confidentiality protection as required by Federal and State law.
- I. Emergency Medical Services units shall document the appropriate information regarding casualties and/or patients using the New Jersey State Disaster Triage Tag, offered by the Office of Emergency Medical Services. The County EOCs will track the patients transported to each hospital and will be able to submit reports to the NJSP EOC upon their request.

III. SITUATION

A. Disaster Condition

1. This annex is to be implemented when local resources, including normal mutual aid, have been overwhelmed by the size of a Mass Casualty Incident (MCI) or a public health threat including outbreak of communicable disease, or acts of terrorism.
2. The sudden onset of a large number of victims would stress the local, county, or regional Emergency Medical Services and hospital systems requiring time-critical assistance from the State government. Incidents involving bio-terrorism will pose increased health threats and place additional strains on Emergency Medical Services and public health resources.
3. Medical and health care facilities, which remain in operation and have the necessary utilities and staff, are likely to be overwhelmed by the "walking wounded," "worried well" and seriously injured victims who are transported there in the immediate aftermath of the event. Medical personnel, supplies (including pharmaceuticals) and equipment are also likely to be in short supply. Disruptions in local communications and transportation systems could prevent timely re-supply. Medical personnel will likely be pulled into a pre-hospital setting to assist in patient triage and treatment. Emergency Medical Services Advanced Life Support personnel will be forced to operate under State standing orders and radio failure protocols and, therefore, supplying hospitals with limited patient condition information while in the pre-hospital setting.
4. While an incident involving chemical, biological, radiological, nuclear and explosive elements may not breach the critical infrastructure of the local medical system, the mass casualties resulting from them are certain to tax

local and State resources. Incidents such as these will produce large numbers of varying injuries and ailments requiring resources not utilized in day-to-day Emergency Medical Services operations.

B. Planning Assumptions

1. Emergency Support Function #8- Public Health and Medical Services Annex is based on a worst possible case scenario.
2. The nature and extent of a disaster requires a pre-planned, immediate and automatic response from the entire ESF #8 organization. This response will be based upon agencies following their SOPs and expanding upon the established procedures and response networks in place and used on a daily basis.
3. Standard communications equipment and practices may be destroyed or rendered inoperable in the disaster. Institution of emergency back up communication devices such as cell station centers, FEMA radios and other telecommunication devices may be needed.
4. Resources within the affected areas may be inadequate to clear casualties from the scene or to treat them in local hospitals.
5. Additional medical resources may be required throughout the disaster area.
6. Operational necessity may require air transport of patients from disaster scene.
7. Disaster conditions may produce a need for mental health crisis counseling. These services may be needed for disaster victims as well as response personnel requiring on-scene interventions such as defusing and over longer periods of time CISD/CISM debriefings.
8. Disruption of the infrastructure such as sanitation services, facilities, loss of electrical power and massing of people in shelters may increase the potential for disease and injury. If resources are available, Emergency Medical Services personnel will be placed in the shelters to be available for patients requiring treatment and transport to the hospital. Shelters will only be staffed if there are ample resources at the scene(s) of the incident(s).
9. The need may arise when severely injured patients require transportation to a hospital outside of the disaster area through the National Disaster Medical System (NDMS).

10. Individuals who self deploy to the scene of a mass casualty incident will be denied access to the staging and scene areas.

IV. Concept of Operations

A. General

1. The New Jersey Department of Health and Senior Services, Office of Emergency Medical Services is the lead coordinating agency for all Emergency Medical Services resources.
2. New Jersey's Basic Life Support needs are served by a mix of volunteer and career Emergency Medical Services organizations. Advanced Life Support needs are served by hospital-based Mobile Intensive Care Programs. Local units are supported by those from contiguous areas. After local mutual aid has been exhausted, additional requests are to be handled by the County Office of Emergency Management Emergency Medical Services Coordinators according to local Standard Operating Procedures.

County Emergency Medical Services Coordinators utilize regional communication centers and/or local MICU dispatch centers to assist with these duties. If the NJSP EOC has been activated, the affected county or counties Emergency Medical Services Coordinator(s) should keep the NJSP EOC informed of their Emergency Medical Services activities. If resources are requested in multiple counties, they should be coordinated through the State Emergency Medical Services Coordinator at the NJSP EOC.

3. The New Jersey Emergency Medical Services (EMS) Task Force is available to provide a rapid and coordinated response of Advanced Life Support (ALS), Basic Life Support (BLS), Emergency Medical Services incident management and other Emergency Medical Services related specialized resources to support local incidents or major pre-planned events.

The EMS Task Force is considered a State resource that will be directed by the DHSS EMS Task Force Coordinator and activated through an on call list placed at the NJSP EOC during large-scale emergencies.

4. The Disaster Medical Assistance Teams (DMAT) can be deployed through the NDMS system. These teams are made up of volunteers from the Emergency Medical Services and medical community and are available to augment medical health care services in a disaster. New Jersey DMAT can be used as a resource in non-declared events as that team will not be activated for federally declared disasters in New Jersey.

5. A Memorandum of Understanding is in place, acted by and through New York City Fire Department is in place and acted by the State of New Jersey Department of Health and Senior Services, Office of Emergency Medical Services and UMDNJ - University Hospital Emergency Medical Services, for mutual aid coordination in disaster situations.

Requests for interstate resources will be received by the Commissioner of Health and Senior Services through the NJSP EOC. The Commissioner will then release the Emergency Medical Services resources for response into New York.

A copy of the MOU is available in the State Emergency Operations Center (EOC).

6. In the event the NJSP EOC is activated, a representative from the DHSS Office of Emergency Medical Services shall report to the NJSP EOC to coordinate all Emergency Medical Services resources as the State Emergency Medical Services Coordinator.

The State Emergency Medical Services Coordinator is responsible for all coordination of all Emergency Medical Services resources in the State. Upon activation of State EOC, the State EMS Coordinator shall immediately notify the following EMS agencies:

- New Jersey State First Aid Council (NJSFAC)
- Medical Transportation Association (MTA)
- New Jersey Association of Paramedic Programs (NJAPP)

The State Emergency Medical Services Coordinator will remain in contact with the County Emergency Medical Services Coordinators and the Regional Communication Centers and/or local MICU dispatch centers to monitor resource requests and fill needs according to priority.

To accomplish this function, the County Emergency Medical Services Coordinators shall work closely with the Medical Transportation Association of New Jersey, the New Jersey State First Aid Council and the New Jersey Association of Paramedic Programs or other available emergency medical services resources.

7. Emergency Medical Services units utilize appropriate hospital facilities throughout the state in an attempt to prevent overloading those hospitals closest to the disaster scene. Patient distribution to regional hospitals is routed through the Emergency Medical Services Branch Director at the incident command.

Regional Communication Centers will be able to provide this information to the EMS Branch Director via the JEMSTAT webpage (www.jemstat.org), the New Jersey Hospital Diversion/Bed Status reporting system.

The primary method of bed status reporting is through the JEMSTAT webpage, secondary method is the Regional Communication Center using the Hospital Emergency Radio Network.

8. If a situation requires Emergency Medical Services resources exceeding those available in the affected or contiguous jurisdiction(s), mutual aid should be requested through the County Emergency Medical Services Coordinator according to the local SOP. In instances where a county needs to request assistance from their neighboring county or counties, a notification call should be made to the DHSS State Emergency Medical Services Coordinator in the NJSP EOC.

When multiple counties have been activated for mutual aid, consideration should be given to coordinating these efforts through the NJSP EOC. County EMS Coordinators shall ensure adequate coverage of local coverage area.

9. County and State radiological teams determine the level of radiation exposure. In the event of a chemical incident, local Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) Teams, County Health Departments, NJDEP Emergency Response Specialists or members of the USEPA Emergency Response Team will handle monitoring. Emergency Medical Services will not enter the hot or warm zone of a hazardous materials incident unless specialized training has been received. Participants with the Emergency Medical Services Task Force will be trained in rendering treatment of these patients while still in the warm zone.
10. Decontamination of radiological or chemically contaminated victims is provided at the scene by HazMat team personnel as described in local Emergency Operations Plans. EMS treatment takes place on-scene in the cold zone and at acute care hospitals after decontamination takes place.
11. The DHSS will identify and activate the appropriate resources for state response. The County Medical Examiners will assess the need to expand and coordinate mortuary services, or to operate temporary morgues and handle identification of multiple fatalities. The County Medical Examiners will be assisted by the State Medical Examiner's Office.
12. Local and County Emergency Medical Services receive reports and requests from the Emergency Medical Services Branch Director at the scene. Emergency Medical Services resources are dispatched to the affected area as needed without stripping any particular area of the state of Emergency Medical Services coverage.
13. All acute care hospitals in New Jersey have disaster plans designed to enable them to expand capacity to accept additional patients. Patients

may also be transported to distant hospitals through the facilities of the NDMS Federal Coordinating Centers should the scope of the incident/emergency require that system to be activated.

14. The local Emergency Medical Services Branch Director provides direction and control of on scene Emergency Medical Services resources. The County Emergency Medical Services Coordinator provides coordination to the NJSP EOC.
15. ESF #8 coordinates with ESF #9 (Law Enforcement) and ESF #4 (Firefighting) for disaster scene activities and ESF #6 (Mass Care) to provide Emergency Medical Services coverage at congregate care shelters. ESF #1 (Transportation) is utilized to obtain buses or other appropriate vehicles to transport ambulatory persons with minor injuries to medical care facilities
16. The Incident Safety Officer as identified by the Incident Command System Flow Chart set forth by the National Incident Management System oversees Emergency Medical Services worker health and safety.
17. Any individuals and/or groups working independent and without direction from a specific authority within the Incident Command System will be considered freelancing. Any freelancers will immediately be removed from the incident location.

B. Organization

1. New Jersey's Emergency Medical Services system is served by a mix of volunteer and career organizations configured in a two-tier system of Basic Life Support (BLS) and Advanced Life Support (ALS) functions. Advanced Life Support services are staffed by Emergency Medical Technician- Paramedics (EMT-P) and/or Mobile Intensive Care Nurses (MICN).
2. Emergency Medical Technician- Paramedics (EMT-P) and/or Mobile Intensive Care Nurses (MICN) operate through a system of on-line medical command with a base station physician when accessible. In situations where on-line medical command is not feasible, Emergency Medical Services personnel can follow standing orders of the MCI guidelines found in N.J.A.C. 8:41.
3. The JEMSTAR Emergency Medical Helicopter Response Program is operated by the New Jersey State Police in cooperation with the DHSS OEMS. Virtua Health Emergency Medical Services and UMDNJ Emergency Medical Services provide the medical team while the Level 1 Trauma Centers at University Hospital in Newark and Cooper Medical Center in Camden provide medical command.

The helicopters are airborne MICUs staffed by State Police pilots, specially trained flight nurses, and flight paramedics. SouthSTAR is operated from Virtua – West Jersey Hospital in Voorhees Township, NJ, while NorthSTAR is operated by University Hospital in Newark, NJ.

Mutual aid is provided on a regular basis by hospital-based programs in Pennsylvania, Delaware and New York who are licensed by DHSS OEMS to provide air medical services.

4. There are two pre-designated communication centers that coordinate all Emergency Medical Services helicopter operations in New Jersey, the Regional Emergency Medical Communications System in Northern New Jersey (973-972-0911) and the Gloucester County Communications Center in Southern New Jersey (856-307-7100). The two centers have duplication and redundancy to support air medical operations in New Jersey if one center was to go off-line or the event that service is interrupted.
5. There are ten designated trauma centers in New Jersey. Three level one-trauma centers and seven level two-trauma centers licensed by DHSS and certified by the American College of Surgeons.
 - i. Level One Trauma Centers
 1. Cooper Medical Center, Camden
 2. Robert Wood Johnson University Medical Center, New Brunswick
 3. University Hospital, Newark
 - ii. Level Two Trauma Centers
 1. Atlantic City Medical Center, Atlantic City
 2. Capital Health System – Fuld Division, Trenton
 3. Jersey Shore University Medical Center, Neptune
 4. Jersey City Medical Center, Jersey City
 5. St. Joseph's Medical Center, Paterson
 6. Hackensack University Medical Center, Hackensack
 7. Morristown Memorial Hospital, Morristown
6. There is one designated burn center, St. Barnabas Medical Center in Livingston
7. New Jersey Poison Information and Education System (NJ PIES) is the designated poison center for the entire state of New Jersey and are available 24 hours a day at 1-800-222-1222.
8. Policy direction, control, and support services are provided by the DHSS Office of Emergency Medical Services, the Primary Agency of this document.

9. Using the assistance of County OEMs and County OEM Emergency Medical Services Coordinators, appropriate locations will be identified for the establishment of Casualty Collection Points (CCPs). Assigning of medical staff to Casualty Collection Points (CCPs) is a local and county responsibility and is done by the Emergency Medical Services Branch Director.
10. The DHSS is represented in the NJSP EOC by the Department Emergency Coordinator. The State Emergency Medical Services Coordinator will report to the NJSP EOC to provide the DHSS Emergency Coordinator with expertise in the Emergency Medical Services system.
11. In a disaster, handling of mass fatalities is a responsibility of the County Medical Examiner. The State Medical Examiner has oversight responsibilities. The County Medical Examiners handle identification of multiple fatalities assisted by the State Medical Examiner's Office.
12. If the County Medical Examiner's resources are insufficient to handle the scope of the disaster, the State Medical Examiner will coordinate operational support by mobilizing additional resources through mutual aid of other County Medical Examiners and, if necessary, acquire Federal assistance to set up a Disaster Temporary Mortuary from the National Disaster Medical System (NDMS) Disaster Mortuary Response Team (DMORT). (Reference Mass Fatality Appendix – State Medical Examiner.)
13. All requests for Emergency Medical Service resources in excess of local capacity are directed through the County OEM Emergency Medical Services located in the county EOC. Should the incident overwhelm the county level, requests shall go through the State Emergency Medical Services Coordinator in the NJSP EOC. These coordinators will prioritize and coordinate the requests.

C. Notification Procedures

1. Initial notification of a disaster or potential disaster is made to the State Office of Emergency Management by telephone (609)-882-2000 (24-hour coverage).
2. The State Director/Deputy of OEM determines State Emergency Operating Center activation, the notifications to be implemented and the level of EOC staffing. The Deputy State Director (or alternate) notifies the Governor's representative and the Attorney General's on-call Deputy of the emergency incident. The State Office of Emergency Management notifies the appropriate DHSS Emergency Coordinator (or alternate) of the supporting agencies by telephone call.

3. Each agency or organization with responsibilities under ESF #8 ensures they have a primary and alternate notification system.

D. Response Actions

1. Initial Actions

- a. When a determination is made that portions ESF #8 needs to be activated, the State Office of Emergency Management notifies government, volunteer and private organizations. Specifically, the DHSS Emergency Coordinator or designee is notified. The DHSS Emergency Coordinator will then activate internal procedures notifying the Office of Emergency Medical Services.
- b. Response agencies ensure that necessary emergency operating facilities, resources and reporting systems are established.
- c. Response agencies establish communications upward, downward, and laterally with the next level - reporting agency.
- d. Response agencies will provide an immediate health and medical assessment and send situation report (SITREP) to NJSP EOC.
- e. The State Emergency Medical Services Coordinator in the NJSP EOC will determine and establish the priorities of response based on field reports received from the County Emergency Medical Services Coordinators
- f. The Local Health Department and DHSS, in conjunction with the affected hospitals, will coordinate additional medical supplies, as needed. The DHSS will request DMAT through the State EOC, if necessary. Emergency Medical Services resources will be requested following mutual aid protocols at the county and state levels as outlined above.
- g. The NJSP EOC will prioritize, coordinate and obtain requests for necessary protective respiratory devices, clothing, equipment, and antidotes, for personnel to perform assigned tasks in weapons of mass destruction (WMD) or CBRNE events.
- h. DHSS Emergency Coordinator will utilize the State Emergency Medical Services Coordinator at the NJSP EOC for expertise and guidance in Emergency Medical Services.
- i. The DHSS will provide support to all other ESFs on an as needed basis.

- j. The NJSP EOC representative will provide for the integration of federal, state and private assets.
- k. Interagency communication will be coordinated for ESF #4, 6, and 10 at the NJSP EOC.
- l. The New Jersey Disaster Triage Tag is the statewide official triage tag that is used during Mass Casualty Incidents. The tags are funded and distributed by the DHSS OEMS.
- m. NJ ESF #8 will provide specific initial actions for each functional area of the ICS system.
- n. When County OEM Emergency Medical Services Coordinators have exhausted local mutual aid plans, the State Emergency Medical Services Coordinator will assist with the coordination of statewide resources. Communications will be managed through the County EOCs and regional communication centers and/or local MICU communication centers.
- o. The ESF #8 representative will establish liaison with ESF #1 (Transportation) for availability of resources for possible movement of large numbers of injured persons or medical supplies. Additionally, ESF #8 coordinates with ESF #9 (Law Enforcement) and ESF #4 (Firefighting) for disaster scene activities and ESF #6 (Mass Care) to provide Emergency Medical Services coverage at congregate care shelters. They also coordinate with the ESF #1 (Transportation) to obtain buses or other appropriate vehicles to transport ambulatory persons with minor injuries to medical care facilities.
- p. When activated, the State Emergency Medical Services Coordinator located in the NJSP EOC will network with the Local MICU Communications Center and/or Regional Coordinating Centers placing Critical Incident Stress Management Teams (CISD/CISM) on alert. This will be facilitated in accordance with the Department of Human Services Annex.
- q. When activated, the State Emergency Medical Services Coordinator located in the NJSP EOC will network with the local MICU communications center and/or Regional Communication Centers to notify hospitals in expected impact area are notified and plans are finalized for possible transfer of patients to outlying hospitals or alternate health care facilities.
- r. The State Emergency Medical Services Coordinator located in the NJSP EOC will utilize the JEMSTAT website to query hospitals of their respective patient care abilities. The two descriptive patient categories that define the hospital's capability are critical and non-critical.

2. Continuing Actions

- a. The State Emergency Medical Services Coordinator will coordinate with the County OEM EMS Coordinator to facilitate response activities and the establishment of staging areas for medical supplies and Emergency Medical Services resources.
- b. Emergency Medical Services agencies maintain continuous surveillance over the availability of resources and report shortages to the County EOC. The County EOC will forward these situation reports regularly to the NJSP EOC.
- c. Administrative support for individuals assisting ESF #8 is provided by their parent agency.
- d. If resources are available, Emergency Medical Services personnel will be placed in the shelters to be available for patients requiring treatment and transport to the hospital. Shelters will only be staffed if there are ample resources at the scene(s) of the incident(s).
- e. The DHSS Emergency Coordinator will coordinate with the local health department and the LINCS agency, as warranted, to assess the satisfaction of vital medical resource shortfalls such as vaccines and personnel through the Emergency Response Team in the NJSP EOC or disaster field office (DFO). The National Disaster Medical System can be activated outside the disaster area. Deployment of New Jersey National Guard air assets and medical personnel will be coordinated with NJDMVA. Additionally, responsible for the coordinated activation of NJ TF-1, Emergency Medical Services Task Force or other state task forces that can dispatch personnel trained in search and rescue tasks and equipment.
- f. The DHSS Emergency Coordinator will request DMAT through the State EOC, if necessary. Local and county emergency management officials, after the general public is evacuated, will manage initial support for victims and rescue workers.
- g. Local and county emergency management officials will coordinate with scene responders in the establishment of designated treatment areas for critically ill patients that cannot be moved. Those patients requiring more invasive care will be relocated to other tertiary centers utilizing critical care ground and air transport systems.
- h. Fiscal controls, accounting, time keeping, and after action reports are submitted by local and county OEM Emergency Medical Services Coordinators to the NJSP Regional Coordinators who then forward them to the NJSP EOC.

- i. The State Emergency Medical Services Coordinator, in conjunction with REMCS and Gloucester County Communications, will establish air transportation to care for individuals from the disaster site and other medical facilities in coordination with ESF #1, County Emergency Medical Services Coordinators and NJ designated air medical helicopter dispatch centers.
- j. All requests from medical facilities will be coordinated through local EOCs to the NJSP EOC and handled by the DHSS Emergency Coordinator.
- k. The designation and assigning of casualty collection points (CCP) is a local and county responsibility performed by the Emergency Medical Services Branch Director in the field. Regional evacuation points are pre-designated in the NDMS EOP and are coordinated through the NDMS representative.
- l. The DHSS Emergency Coordinator in the NJSP EOC will insure that all patient information is entered into the NDMS patient evacuation system.
- m. The DHSS Emergency Coordinator will, in conjunction with the affected hospitals, coordinate additional medical equipment and supplies.
- n. The DHSS Emergency Coordinator will coordinate within the EOC specific continuing actions for each functional area.
- o. The DHSS Emergency Coordinator will coordinate requests for on site crisis counseling and long - term stress debriefing with local and county emergency management officials. The state CISD/CISM coordinator establishes response methods, notification, and contact number information in the CISM Appendix F.
- p. After action reports are submitted by local and county OEM Emergency Medical Services Coordinators, and the NJSP Regional Coordinators who then forward them to the NJSP EOC.

V. Responsibilities

A. Primary Agency –

New Jersey Department of Health and Senior Services:

The New Jersey Department of Health and Senior Services will:

- 1. Annually review the Plan, including other annexes, submit comments as appropriate and revise this annex as necessary.

2. Develop additional plans, SOPs or guidance in sufficient procedural detail to insure successful response and recovery during a disaster.
3. Designate representatives for the NJSP EOC.
4. Participate in training and exercises at the Federal, State and County level.
5. Insure personnel are properly trained to implement this plan.
6. Maintain current internal personnel notification/recall rosters and implementation procedures as an integral part of ESF #8 SOPs.
7. Task additional support agencies and private organizations as necessary, to accomplish the ESF #8 mission.
8. Insure that SITREPs are provided to the NJSP EOC in accordance with the direction and control appendix.
9. Initiate requests for assistance from federal and private health agencies and establish liaison with federal, state and private health agencies. Coordinate support of NJ ESF through the State Coordinating Officer (SCO).
10. Provide technical, coordination, and administrative support, personnel, facilities, and communications for this ESF.
11. Provide leadership in directing, coordinating, and integrating the overall State health and medical services effort.
12. In response to requests for State assistance direct and activate the deployment of health and Emergency Medical Services resource needs and provide for the prioritizing or allocation of available supporting resources, if required.
13. Provide information on damage to health care and medical facilities. Oversee evacuation of hospitals and health care facilities. Provide situation reports on vital statistics, casualties, health problems and medical services. Monitor for epidemics and provide immunization activities.
14. Designate the American Red Cross as the designated lead agency in providing human services assistance, specifically family reunification.
15. Develop procedures to distribute antidotes, drugs, vaccines, etc. to shelters and other designated treatment areas of the disaster site in conjunction with the bio-terrorism annex.

16. Refer all treatment and decontamination of CBRNE contaminated victims at incident scenes to the Emergency Medical Services TF HazMat team. This is facilitated through local, county and state HazMat response teams.
17. Refer to the County and State radiological teams to determine the level of radiation exposure. These organizations provide dosimeter readings at appropriate frequencies and maintain all exposure records in coordination with ESF #10. In the event of a chemical incident, local Hazardous Materials Teams, County Health Departments, NJDEP Emergency Response Specialists or members of the USEPA Emergency Response Team will handle monitoring.
18. Accomplish assignments outlined in the Emergency Procedures Directory.
19. Assure that After Action Reports (AARs) are submitted.
20. Serve as the focal point for guidance and assistance to other state agencies, counties, municipalities, private and volunteer organizations in all matters pertaining to health and Emergency Medical Services.
21. Coordinate the acquisition of medical, health and Emergency Medical Services personnel, equipment and supplies.
22. Provide clinical and environmental laboratory support, as needed.
23. Coordinate statewide health and sanitation operations including the monitoring of health situation reports from county, regional and municipal health officials.
24. Develop emergency standards and guidelines, and provide technical assistance to state agencies, regions, counties, and municipalities on general health and sanitation problems and medical services. Furnish the public with emergency information relevant to these problems.
25. Insure the following lists and documents are maintained and available when needed:
 - a. Available Emergency Medical Services Helicopter Programs for Air Medical Support;
 - b. Trauma Center and Burn Center designated institutions;
 - c. Advanced Life Support Providers;
 - d. Mobile Intensive Care Unit Trauma and Triage Protocols;
 - e. MICU Dispatch Protocols;

- f. County OEM Emergency Medical Services Coordinators;
- g. Licensed Ambulance and Mobility Assistance Vehicle providers;
- h. New Jersey Acute Care Facilities;
- i. New Jersey State First Aid Council Directory;
- j. Advanced Life Support personnel;
- k. Basic Life Support personnel; and
- l. Ensure, in concert with NJOEM, that this annex is coordinated with the following plans. Copies are available in the EOC:
 - (1) County Emergency Medical Services Annexes;
 - (2) Port Authority of NY and NJ Newark Airport Disaster Plan;
 - (3) NDMS Plans; and
 - (4) New Jersey Hospital Association.
- m. EMS Task Force.

B. Support Agencies:

1. The supporting agencies will annually review the Plan, including other annexes, submit comments as appropriate and revise this annex, as necessary.
2. The support agencies will participate in training and exercises at the Federal and State level.
3. The support agencies will develop additional plans, SOPs or guidance in sufficient procedural detail to insure successful response and recovery during a disaster. Additionally, provide the primary agency with points of contact at the state level for coordination of planning and response.
4. The support agencies will designate representatives, as required, to the primary agency in the NJSP EOC.
5. The support agencies will insure personnel are properly trained to implement this plan.

6. The support agencies will publish After Action Reports (AARs) to the primary agency.
7. The support agencies will insure the following lists and documents are maintained and available for the primary agency when needed:
 - a. Available Emergency Medical Services Helicopter Programs for Air Medical Support;
 - b. Trauma Center and Burn Center designated institutions;
 - c. Advanced Life Support Providers;
 - d. MICU Trauma and Triage Protocols;
 - e. MICU Dispatch Protocols;
 - f. County OEM Emergency Medical Services Coordinators;
 - g. Licensed Ambulance and Mobility Assistance Vehicle providers;
 - h. New Jersey Acute Care Facilities;
 - i. New Jersey State First Aid Council;
 - j. Pre-hospital Advanced Life Support personnel;
 - k. Basic Life Support personnel;
 - l. Insure, in concert with NJOEM, that this annex is coordinated with the following plans and copies are available in the EOC:
 1. County Emergency Medical Services Annexes;
 2. Port Authority of NY and NJ Newark Airport Disaster Plan;
 3. NDMS Plans; and
 4. New Jersey Hospital Association.
 - m. EMS Task Force.

VI. Resource Requirements

- A. Health/Medical personnel can be augmented through local, county, and/or regional Emergency Medical Services mutual aid, EMS Task Force, American Red Cross resources, NJ National Guard personnel, NJ TF-1 urban search and rescue, interstate Emergency Medical Services mutual aid and National Disaster Medical System personnel.
- B. As part of their disaster planning, hospitals must make space to receive victims of a mass casualty incident. Patients will be transferred to other facilities where maintained beds are available or excess of licensed beds can be promptly made available with added staff. Among hospitals capable of rapid expansion are the former military hospitals at Fort Dix (Walson) and Fort Monmouth (Paterson), VA Hospitals in East Orange and Lyons, and some hospitals in the urban areas of Northern New Jersey. The number and location of available beds changes daily. In addition to Acute Care Hospitals, there are Long-term Care facilities, Psychiatric Care facilities, Rehabilitation, County, and State Hospitals, which also can be activated.

Local MICU communication centers or Regional Coordination Centers will provide an important service by monitoring the bed status of hospitals by utilizing the JEMSTAT website in their service areas. This information is provided to the Emergency Medical Service Branch Director to ensure optimum patient distribution. In the event of a Mass Casualty Incident, NDMS, through the FCCs in Lyons and Philadelphia, will have the lead role in locating beds at out-of-state facilities for excess patient load and the interstate transport of those patients. This responsibility will include beds in specialty areas such as burns, neurological, pediatric ICU, etc.

- C. Supplies and equipment to support Emergency Medical Services operations are obtained from local sources whenever possible. In large-scale incidents, supplies can be made available through Federal agencies or contacts from agencies such as the New Jersey Hospital Association's group purchasing program. Plans should be made locally to obtain equipment from suppliers during off hours in emergency situations. Hospitals may be able to provide limited quantities of supplies in emergency situations.
- D. Aero Regional Evacuation Points (AREPs) in New Jersey include Newark Airport, McGuire AFB, Philadelphia International Airport and other spoke distribution points, as needed.
- E. Crisis augmentation of emergency workers will be implemented by the DHSS for regulatory oversight and confirmation of credentials. The American Red Cross (ARC) will be responsible for monitoring all ARC volunteers and personnel. Mutual aid agreements will be exercised while maintaining confirmation of appropriate credentials for all responders. Additional volunteers such as nurses, EMTs, Paramedics, Physicians, and other trained volunteers will be coordinated through a resource pool managed by the NJSP EOC. Freelancing volunteers and those responders without identification will be managed and prevented from operating within any sectors of the disaster.

VII. Authorities and References-

A. Federal References

1. US Public Law 93-288, The Disaster Relief Act of 1974

B. State References

1. New Jersey Public Law 1970, Chapter 33 (N.J.S.A. 13:1D-1)
2. Emergency Management Act, N.J.S.A. App. A:9-33 et seq.
3. New Jersey Public Law 1975, Chapter 232 (N.J.S.A. 13:1D-29)
4. New Jersey Public Law 1947 N.J.S.A. 26A-1 et seq.
5. New Jersey Administrative Code, N.J.A.C. 8:51.

VIII. Acronyms / Abbreviations / Definitions

A. Federal Terms and Definitions

AAR-	After Action Report
ARC-	American National Red Cross
ARNG-	Army National Guard
AREP-	Aero Regional Evacuation Point
CCP-	Casualty Collection Point
DFO-	Disaster Field Office
DVA-	Department of Veterans Affairs (Federal)
DWI-	Disaster Welfare Information System (ARC)
EOC-	Emergency Operations Center
EOP-	Emergency Operations Plan
ERT-	Emergency Response Team
FEMA-	Federal Emergency Management Agency

JIC- Joint Information Center
NDMS- National Disaster Medical System
SOP- Standard Operating Procedure
USEPA- United States Environmental Protection Agency
USPHS- United States Public Health Service

B. State Terms and Definitions

EMS TF- Emergency Medical Services Task Force
JEMSTAR- Jersey Emergency Medical Shock Trauma Air Rescue Helicopter
NORTHSTAR- Northern Shock Trauma Air Rescue Helicopter
SOUTHSTAR- Southern Shock Trauma Air Rescue Helicopter
RCC- Regional Communications Center
NJSFAC- New Jersey State First Aid Council
NJOEM- New Jersey Office of Emergency Management
OEMS- New Jersey Office of Emergency Medical Services
MOU- Memorandum of Understanding
PEOSH- Public Employee Occupational Safety and Health
NJDMVA- New Jersey Department of Military and Veterans' Affairs
NJDEP- New Jersey Department of Environmental Protection
DHSS- New Jersey Department of Health and Senior Services
ESF- New Jersey Emergency Support Function
LINCS- Local Information Network and Communications System

C. Other Emergency Management Related Terms and Abbreviations

MCI- Mass Casualty Incident
MICN- Mobile Intensive Care Nurse

EMT-B- Emergency Medical Technician- Basic

EMT-P- Emergency Medical Technician - Paramedic

MICU- Mobile Intensive Care Unit

CISM- Critical Incident Stress Management

EMSBD- Emergency Medical Service Branch Director

ED- Emergency Department

ALS- Advanced Life Support

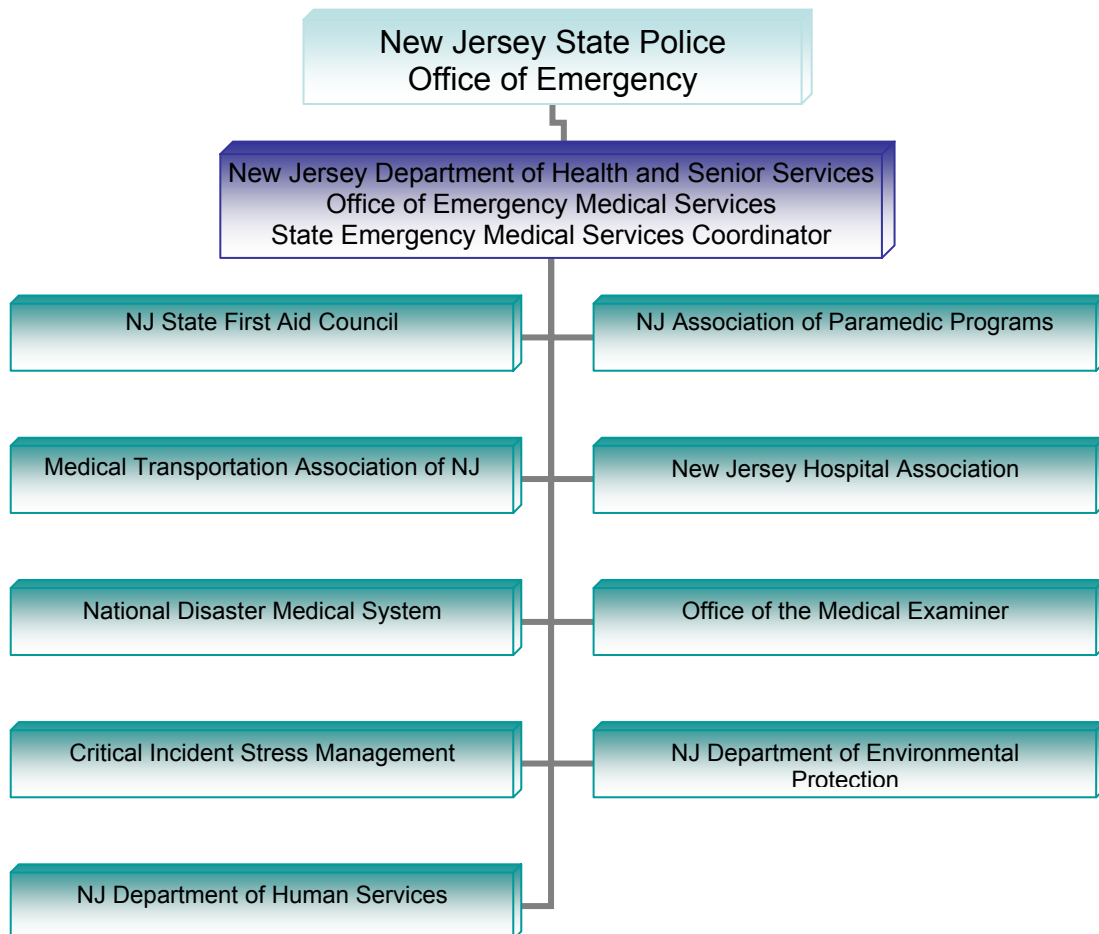
BLS- Basic Life Support

EMS- Emergency Medical Service

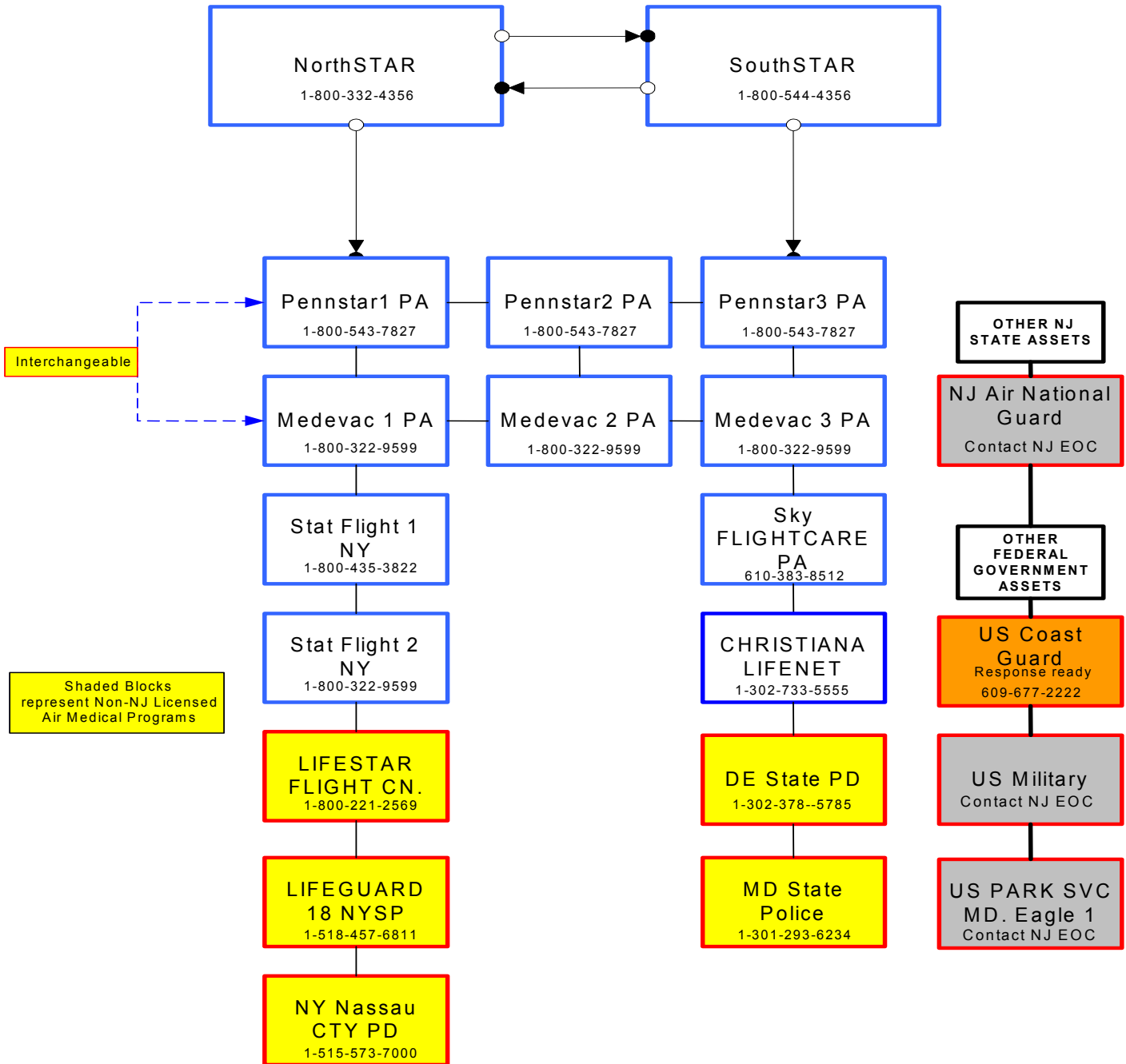
SITREP- Situation Reports

IMAT- Incident Management Assistance Teams

Appendix A- NJ Emergency Operation Plan of ESF #8- EMS Annex



Appendix B- NJ Air Medical Response System



Appendix C – National Disaster Medical System

National Disaster Medical System Operations Plan—New Jersey Revised 12/19/01

The Concept and Mission of the National Disaster Medical System

The National Disaster Medical System (NDMS) is an organizational structure administered by the Federal Government to provide emergency medical assistance to states and territories following a catastrophic disaster or other emergency. It is usually activated when the catastrophic disaster overwhelms both local and state resources. It is designed to supplement other resources and is oriented primarily to large-scale disasters in which local medical care capabilities are severely strained or overwhelmed. NDMS has two primary missions:

1. To supplement state and local medical resources during major domestic natural and manmade catastrophic disasters and emergencies.
2. To provide backup medical support to the Department of Defense (DoD) and Department of Veterans Affairs (VA) medical systems in providing care for U.S. Armed Forces personnel who become casualties during overseas conventional conflicts.

NDMS is administered as a partnership between VA, DoD, Federal Emergency Management Agency (FEMA) and the Office of Emergency Preparedness of the Department of Health and Human Services (HHS). In New Jersey, NDMS is administered by the Emergency Management Strategic Healthcare Group (EMSHG) of the Department of Veterans Affairs. North and Central New Jersey are administered from the Lyons Campus of the VA New Jersey, Health Care System, and Southern New Jersey is administered from the Philadelphia VA Medical Center.

In peacetime activation, which generally consists of domestic natural or manmade catastrophic disasters, NDMS has the following objectives:

To provide health, medical and related social service response to a disaster area in the form of medical response units or teams and medical supplies and equipment.

To evacuate patients who cannot be cared for in the affected area to designated locations, elsewhere in the nation.

To provide hospitalization in Federal hospitals and a voluntary network of non-federal acute care hospitals that have agreed to accept patients in the event of a national emergency.

To carry out these three objectives, NDMS has three sets of organizational resources:

Disaster Medical Assistance Teams and Medical Professionals from VA, DoD and DHHS. Disaster Medical Assistance Teams (DMATs) are voluntary medical manpower units organized and equipped to provide austere medical care in a disaster area or medical services at disaster points or reception sites associated with patient evacuation. Hospitals, volunteer agencies or health and medical organizations sponsor DMATs and recruit interested medical and paramedic personnel to participate. In New Jersey, the Level I NJ1 DMAT Team is sponsored by the NJ State Naval Militia. Besides general DMATs, specialized units have been formed for pediatric care; burn care, veterinary services, mental health and disposition of the deceased. In addition, field medical and related services are provided by federal health professionals from VA, DoD and DHHS.

Casualty Evacuation System. Movement of patients from disaster sites to locations where definitive medical care can be provided is administered through DoD. Casualty tracking is conducted using Trans-Aid developed at the Hudson Valley VA HealthCare System.

Definitive Medical Care Network. NDMS has enrolled over 110,000 reserve beds in over 1,800 participating civilian hospitals to receive casualties from disaster areas. Maintaining the New Jersey NDMS network is the responsibility of the Department of Veterans Affairs (EMSHG) Federal Coordinating Centers at:

Northern and Central

VA Medical Center
151 Knollcroft Road
Building 26/Apartment 22
Lyons, New Jersey 07939
(908) 647-0180 ext. 4584
FAX: (908) 657-5057

Southern

VA Medical Center
University & Woodland Ave.
Philadelphia, PA 19104
(215) 823-5890
FAX: (215) 823-6008

The entire NDMS or selected components can be activated in several ways. The Governor of a State can request assistance from the President who, in turn, can either declare a disaster or order activation of Federal Assistance to that State. Currently such activations are authorized under the Stafford Act of 1988 and administered through the Federal Response Plan of 1992 coordinated through FEMA. The Public Health Service Act also authorizes Federal Departments and Agencies to provide medical assistance on request of state and local authorities, and NDMS is an authorized vehicle for such assistance. The Secretary of Defense can also activate NDMS in situations of National

Emergency. Requests for reimbursement should be directed to the addresses as appropriate.

Integration of NDMS with the Federal Response Plan

In 1988, Congress passed and the President signed the Robert T. Stafford Disaster Relief and Assistance Act (Public Law 100-707), which essentially established the integrated Federal disaster response structure that we have today. It consolidated a series of existing authorities for specialized disaster response in the hands of FEMA, and firmly reinforced two principles of Federal disaster assistance policy. First, the Federal role was to assist states and localities with catastrophic disaster response in situations where state and local capacity proves inadequate to handle the situation. Along with this, there is a charge to assist and otherwise insure that state and local preparedness is strengthened. Catastrophic disaster response, like public health, remains a state responsibility. In New Jersey, this responsibility resides with the New Jersey Office of Emergency Management (NJOEM).

Second, Federal Catastrophic disaster response is aimed at using existing resources, not creating new ones at the Federal level. Federal agencies with existing responsibilities for disaster related programs are "networked" under FEMA direction, rather than creating a new Federal disaster agency. DHHS is assigned responsibility to support FEMA for health, medical and health related human services. Some of these are within NDMS. These services are components of Emergency Support Function (ESF) #8 of the Federal Response Plan (FRP). The ESF #8 portion of the FRP is included as an annex to this plan.

Over the next four years, a Federal structure for carrying out the Stafford Act was worked out, resulting in the publication of the FRP in 1992. Under the FRP, 12 ESFs with DHHS assigned lead responsibility for ESF #8 health, medical and health related human services support. In the FRP, 16 medical support activities are associated with ESF #8, three of which are explicitly identified as NDMS responsibilities and three strongly associated with NDMS. In addition, NDMS partner agencies and other Federal offices are designated support agencies in carrying out ESF #8 functions. The National Disaster Medical System, as it currently exists, finds its authority under the Stafford Act/Federal Response Plan, through interagency agreements between partner agencies, and through a series of orders and directives issued on behalf of partner agencies.

Integration of Federal, State and Local Plans

Catastrophic disaster response involves a complex set of interactions among agencies at a number of governmental levels. Effective response also involves interaction with non-governmental organizations at each level. Formal plans usually focus on coordination at a particular level and are often less adequate in addressing the relationships among the various levels.

In order to be fully effective, catastrophic disaster plans must address the requirements for communication and coordination among governmental levels. A major element of

the NDMS is to develop a set of plans for the program that are fully integrated at the federal, state and local levels. Integration involves coordinated deployment of medical resources as well as effective relationships between medical and non-medical disaster response organizations. As with the Federal Response Plan, the State of New Jersey, through the Office of Emergency Management, developed a State Response Plan, with ESFs mirroring the Federal Plan. The Health and Medical Annex to the NJ State Response Plan is included as an annex to this NDMS Operations Plan. You will notice the role of NDMS/VA activities in the State Plan.

Participating Hospital Response and Responsibilities

Civilian hospitals that voluntarily participate in the National Disaster Medical System have each executed a Memorandum of Understanding (MOU) with the Federal Government. In accordance with the MOU, participating hospitals have agreed to provide medical treatment for patient casualties resulting from a natural, technological or manmade disaster. In addition, participating hospitals have agreed to participate in developing and testing this NDMS Operations plan. Finally, each hospital will fulfill such administrative obligations as necessary to ensure proper coordination of the medical response. Specifically, each NDMS hospital will:

- A. Maintain an internal mass casualty plan, which describes the hospital's role and actions in case of NDMS activation.
- B. Designate a staff member to serve as NDMS Representative (Point of Contact) and notify NDMS Federal Coordinating Centers at Lyons, NJ and Philadelphia, PA, as appropriate, of any change in status.
- C. Review bed availability by the 13 patient categories as requested periodically, and report changes in status to FCCs at Lyons, NJ and Philadelphia, PA, as appropriate. The 13 categories, with their corresponding codes are:

- Medicine (MM)
- Psychiatry (MP)
- General Surgery (SS)
- Neuro-surgery (SSN)
- Maxillo-facial (SSM)
- Ophthalmology (SSO)
- Thoracic Surgery (SSCT)
- Urology (SSU)
- Orthopedics (SO)
- Spinal Cord Injury (SCI)
- Burns (SBN)
- OB/GYN (SG)
- Pediatrics (MC)

It is understood that the types and numbers of beds available at each hospital vary greatly depending on the hospital mission and workload. Under NDMS activation, bed availability is initiated by CENCOM in North and Central New Jersey and by Camden County OEM in Southern New Jersey. These organizations in turn contact the state communication centers (REMCS, MI-COM, HUD-CEN, MED-CENTRAL, Gloucester

County) who contact the hospitals they deal with on a daily basis, and then report back to the NDMS Area Emergency Managers at VAMC Lyons, NJ, for Northern and Central NJ and the Area Emergency Manager and VAMC Philadelphia, PA for Southern NJ. The Area Emergency Managers report the aggregate number of beds available to the Global Patient Movement and Requirements Center (GPMRC) at Scott Air Force Base, Illinois. Based on this information, GPMRC will decide the number and category of patients will send to New Jersey. This information will be disseminated by the NDMS Area Emergency Manager to **CENCOM** for Northern and Central NJ, and **Camden County OEM** for Southern NJ, who will then contact the other communication systems statewide for determination of patient distribution protocol. Patients will then be distributed to participating hospitals, based on their bed availability.

Patient transport to participating NDMS hospitals will be accomplished by contacting the New Jersey Office of Emergency Management at 609-882-2000, who will in turn activate appropriate personnel for coordination of ALS and BLS services.

General Information

NDMS will compensate participating hospitals as determined by statute. Bills for services rendered will be presented to the NDMS Area Emergency Manager for disposition.

Instructions concerning discharge of patients to their point of origination, as well as procedures for inter-hospital transfers will be disseminated as necessary. Hospitals are to notify their respective NDMS Area Emergency Manager prior to undertaking those actions.

In the event of military conflict, combat casualties may be received by civilian NDMS participating hospitals. Medical care provided to members of the Armed Forces will be provided in accordance with customary hospital practice. Additional administrative procedures are necessary as required by the Department of Defense, however, civilian hospitals need not be concerned as part of this plan. Should military casualties be cared for at your facility, instructions will be disseminated in a timely manner.

During NDMS exercises, alerts and activations, the NDMS Operations Centers at VAMC Lyons, New Jersey and VA Philadelphia, PA will be opened as required. Questions and concerns regarding NDMS activities should be referred to Andrew G. Flacks, Area Emergency Manager at (908) 647-0180 x4584 or 1-888-765-6493 (24 Hour Page) for Northern and Central NJ and David M. Berg, Area Emergency Manager at (215) 823-5890 or 1-888-765-6475 (24 hour Page). They may also be reached through VA EMSHG Operations at 304-264-4800.

Participating NDMS Agencies

Department of Veterans Affairs Medical Center, Lyons, New Jersey

Department of Veterans Affairs Medical Center, Philadelphia, Pennsylvania

New Jersey State Department of Health and Senior Services
Department of Health and Human Services, Public Health Service, Region II
Federal Emergency Management Agency, Region II
Joint Regional Medical Planning Office, US Armed Forces Command
New Jersey Office of Emergency Management, NJ State Police
New Jersey State First Aid Council
New Jersey Voluntary Organizations Active in Disasters (VOAD)
County Offices of Emergency Management
American Red Cross
Salvation Army
Military Affiliate Radio System (MARS)
Amateur Radio Relay League (ARRL)
Amateur Radio Emergency Services (ARES)
CENCOM Communication System
Camden County Office of Emergency Management
Regional Emergency Medical Communication System (REMCS)
MI-COM Communication System
MED-CENTRAL Communication System
HUD-CEN Communication System

Appendix D- Management of Multiple Thermal Casualties

SAINT BARNABAS MEDICAL CENTER MANAGEMENT OF MULTIPLE THERMAL CASUALTIES

PURPOSE: To provide guidelines for the management of patients in the event of concurrent multiple thermal injuries and to establish transfer routes, if an unmanageable number of victims of a thermal disaster were brought to Saint Barnabas Medical Center.

POLICY: The Burn Center Medical Director or designee will manage the triage of thermally injured patients in the event of concurrent multiple thermal injury. Additionally, the Burn Administrator on call will coordinate personnel, supplies and interdepartmental responsibilities along with notification on administration.

PROCEDURE:

1. Upon receiving notification of multiple admissions simultaneously, the BICU charge nurse will notify the Burn Surgeon, Burn Administrator on call and Nursing Supervisor.
2. When the Clinical Manager is not available within the Medical Center, the charge nurse will reassign her patients for ease of coordination of activities until Manager on-call arrives.
3. The triage of all thermal casualties will be coordinated by the Burn Surgeon on-call, sending facilities, Emergency Department physician and at scene paramedics in conjunction with CENCOM.
4. Methods of transportation from another facility to Saint Barnabas Medical Center will be approved by the Burn Surgeon. If it is established that air transport is required, the sending facility will notify NorthSTAR/SouthSTAR of New Jersey. Covering air transport from New York or Pennsylvania will be utilized as needed.

Patients will be triaged to the Emergency Department and/or Burn Center. Hydrotherapy areas of BICU and BSDU will be utilized for initial assessment of all patients along with the Emergency Department Trauma Room.

Burn Management Team will be called in to assist with casualties by on-call manager as needed.

Additional Burn Team members will be notified by the manager on-call or designee as needed. This will include, but not limited to

Physical and Occupational Therapy, Social Service, Paramedics, Pastoral Care and Environmental Services.

Nursing Director or designee will communicate with Administrator on-call regarding the Burn Center status. Additionally, all communication with department heads, public relations, and the media will be the responsibility of the Nursing Director or designee.

The necessity for additional staff, supplies and equipment will be communicated by the manager on-call or designee to each department.

All nursing staff needs will be coordinated by the Clinical Managers or designee in collaboration with the Staffing Center.

An assessment of the capacity of the Burn Center to admit burn disaster victims will be made on a daily basis by the Nursing Director, the Clinical Manager or designee.

The Nursing Director or designee in conjunction with the Director of Cardiac Services will ascertain the number of beds which could be made available in the event of a thermal disaster.

The capacity of the hospital to handle disaster victims of a lesser magnitude (less critically injured victims) will be ascertained in consultation with the Administrator on-call, the Nursing Department, and the Department of Admissions or designee. This information will be obtained by the Nursing Director and conveyed to the Burn Medical Director.

The numbers of burn victims requiring hospitalization, but in excess of the capacity of Saint Barnabas Medical Center, will be transferred after communication by the Burn Center Medical Director, with the following facilities (having regard to proximity and capacity of the receiving facility):

- a. Erie County Medical Center, Burn Treatment Center – Buffalo, New York – 6 beds – (716) 898-5231
- b. Nassan County Medical Center, Burn Center, East Meadow, New York – 18 beds – (516) 572-3207
- c. St. Joseph's Hospital, Burn Unit, Elmira, New York – 8 beds – (607) 733-6541
- d. Jacobi Medical Burn Center, New York, New York – 11 beds – (718) 918-7000

- e. New York Hospital Burn Center, New York, New York – 46 beds – (212) 746-5317
- f. Strong Memorial Hospital, Burn Unit, Rochester, New York – 9 beds – (716) 275-5473
- g. Suny Health Science Center, Burn Unit, Syracuse, New York – 10 beds (315) 464-6083
- h. Westchester County Medical Center, Burn Center, Valhalla, New York – 10 beds (914) 285-8680
- i. Good Samaritan Hospital Burn Program, West Islip, New York – (516) 587-7800
- j. Lehigh Valley Hospital, Burn Center, Allentown, PA – 6 beds – (610) 402-8735 and (610) 402-8734
- k. Saint Agnes Burn Center, Philadelphia, PA – 11 beds – (215) 339-4339
- l. St. Christopher's Hospital for Children, Pediatric Burn Center, Philadelphia, PA – 5 beds (215) 427-5000
- m. Crozer Chester Medical Center, The Nathan Speare Regional Burn Treatment Center, Upland, New York – 17 beds – (215) 384-3728
- n. Bridgeport Hospital Burn Center, Bridgeport, CT – 14 beds – (203)384-3728

Appendix E- NDMS Bed Status Assignments Assignments as of January 2002

REMCS

Clara Maas Medical Center	
Columbus Hospital	
East Orange General Hospital	
Hospital Center at Orange	
Newark Beth Israel Medical Center	
St. James Hospital	
St. Michael's Medical Center	
UMDNJ - University Hospital	Level I

MI-COM

Barnert Hospital	
Bergen Regional Medical Center	
Chilton Memorial Hospital	
Englewood Hospital & Medical Center	
Hackensack University Medical Center	Level II
Holy Name Hospital	
Pascack Valley Hospital	
Passaic Beth Israel Hospital	
St. Joseph's Hospital and Medical Center	Level II
St. Joseph's Wayne Hospital	
St. Mary's Hospital - Passaic	
The General Hospital Center at Passaic	
The Valley Hospital	

CEN-COM

Essex County Hospital Center	
Hackettstown Community Hospital	
Irvington General Hospital	
Morristown Memorial Hospital	Level II
Newton Memorial Hospital	
Overlook Hospital	
Robert Wood Johnson University Hospital @ Rahway	
St. Barnabas Medical Center	Burn Center
St. Clare's Denville	
St. Clare's Dover	
St. Clare's Sussex	
The Mountainside Hospital	

Trinitas - St. Elizabeth's
Trinitas - Williamson Campus
Union Hospital
Warren Hospital

HUD-CEN

Bayonne Hospital	
Christ Hospital	
Jersey City Medical Center	Level II
Meadowlands Hospital Medical Center	
Palisades Medical Center	
St. Francis Hospital	
St. Mary Hospital	
West Hudson Hospital	

Camden County Communications

A.C. Medical Center - City Division	Level II
A.C. Medical Center - Mainland Division	
Burdette Tomlin Memorial Hospital	
Cooper University Hospital	Level I
Deborah - Heart and Lung Center	
Hampton Hospital	
Kennedy Memorial Hospitals - UMC - Cherry Hill	
Kennedy Memorial Hospitals - UMC - Stratford	
Kennedy Memorial Hospitals - UMC - Washington Township	
Our Lady of Lourdes Medical Center	
Rancocas Hospital	
Shore Memorial Hospital	
South Jersey Hospital - Bridgeton	
South Jersey Hospital - Elmer	
South Jersey Hospital - Millville	
South Jersey Hospital - Newcomb	
The Memorial of Salem County	
Underwood Memorial Hospital	
Virtua - Memorial Hospital Burlington County	
Virtua - West Jersey Hospital - Berlin	
Virtua - West Jersey Hospital - Marlton	
Virtua - West Jersey Hospital - Voorhees	

Robert Wood Johnson - Med Central

Bayshore Community Hospital

Capital Health System - Fuld Campus	Level II
Capital Health System - Mercer Campus	
CentraState Medical Center	
Community Medical Center	
Hunterdon Medical Center	
Jersey Shore Medical Center	Level II
JFK Medical Center	
Kimball Medical Center	
Medical Center of Ocean County	
Monmouth Medical Center	
Muhlenberg Regional Medical Center	
Raritan Bay Medical Center - Old Bridge Division	
Raritan Bay Medical Center - Perth Amboy Division	
Riverview Medical Center	
Robert Wood Johnson University Hospital	Level I
Robert Wood Johnson University Hospital @ Hamilton	
Somerset Medical Center	
Southern Ocean County Hospital	
St. Francis Medical Center	
St. Peter's University Hospital	
The Medical Center at Princeton	

Appendix F- Critical Incident Stress Management

The Critical Incident Stress Management Network of New Jersey

Since 1988, the New Jersey Critical Incident Stress Management (CISM) Network has provided stress management interventions to New Jersey Emergency Services agencies. The Network is made up of Teams that cover the entire state and can be activated by calling our central dispatch number **1-866-NJS-CISD**, which is covered by Lifecom, 24-hour 911 Center in Mercer County. The members of the Teams are made up of Mental Health Professionals and Peer Support Personnel specially trained in CISM. The NJ CISM Network is a member of the International Critical Incident Stress Foundation (ICISF) based in Maryland. Members of the NJ CISM Teams are trained following the guidelines of ICISF. The NJ CISM Network is part of the New Jersey State Police Office of Emergency Management Plan.

CISM has two major goals when dealing with Emergency Personnel after a critical incident; 1) timely emotional support and return to service and 2) to mitigate the negative effects of distress with the ultimate goal of preventing post-traumatic stress disorder.

Tragedies, deaths, serious injuries, hostage situations, threatening situations - these events are known as "Critical Incidents." People who respond to emergencies encounter highly stressful events almost every day. Sometimes an event is so traumatic or overwhelming that emergency responders may experience significant stress reactions.

Critical Incident Stress Management (CISM) represents an integrated "system" of interventions, which is designed to prevent and/or mitigate the adverse psychological reactions that so often accompany emergency services, public safety, and disaster response functions. CISM interventions are especially directed towards the mitigation of post-traumatic stress reactions.

SIGNS AND SYMPTOMS OF CRITICAL INCIDENT STRESS

chills	Confusion	fear	withdrawal
thirst	Nightmares	guilt	antisocial acts
fatigue	Uncertainty	grief	inability to rest
nausea	Hypervigilance	panic	intensified pacing
fainting	Suspiciousness	denial	erratic movements
twitches	intrusive images	anxiety	change in social activity
vomiting	blaming someone	agitation	change in speech patterns
dizziness	poor problem solving	irritability	loss of or increase in appetite
weakness	poor abstract thinking	depression	hyperalert to environment
chest pain	poor attention/ decisions	intense anger	increased alcohol consumption
headaches	poor concentration/memory disorientation of time, place or person	apprehension	change in usual communications
elevated BP	difficulty identifying objects or people heightened or lowered alertness	emotional shock	etc...
rapid heart rate	increased or decreased awareness of surroundings	emotional outbursts	
muscle tremors	etc...	feeling overwhelmed	
grinding of teeth		loss of emotional control	
shock symptoms		inappropriate emotional response	
visual difficulties		etc...	
profuse sweating			
difficulty breathing			
etc...			

Any of these symptoms may indicate the need for medical evaluation. When in doubt, contact a physician.

Some Things To Try To Mitigate CIS Effects

WITHIN THE FIRST 24 - 48 HOURS periods of appropriate physical exercise, alternated with relaxation will alleviate some of the physical reactions.

Structure your time - keep busy.

You're normal and having normal reactions - don't label yourself crazy.

Talk to people - talk is the most healing medicine.

Be aware of numbing the pain with overuse of drugs or alcohol; you don't need to complicate this with a substance abuse problem.

Reach out - people do care.

Maintain as normal a schedule as possible.

Spend time with others.

Help your co-workers as much as possible by sharing feelings and checking out how they are doing.

Give yourself permission to feel rotten and share your feelings with others.

Keep a journal; write your way through those sleepless hours.

Do things that feel good to you.

Realize those around you are also under stress.

Don't make any big life changes.

Do make as many daily decisions as possible which will give you a feeling of control over your life, i.e., if someone asks you what you want to eat - answer them even if you're not sure.

Get plenty of rest.

Recurring thoughts, dreams or flashbacks are normal - don't try to fight them - they'll decrease over time and become less painful.

Eat well-balanced and regular meals (even if you don't feel like it).

FOR FAMILY MEMBERS & FRIENDS

Listen carefully.

Spend time with the traumatized person.

Offer your assistance and a listening ear if they have not asked for help.

Reassure them that they are safe.

Help them with everyday tasks like cleaning, cooking, caring for the family, minding children.

Give them some private time.

Don't take their anger or other feelings personally.

Don't tell them that they are "lucky it wasn't worse" - traumatized people are not consoled by those statements. Instead, tell them that you are sorry such an event has occurred and you want to understand and assist them.